

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10537

10545

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester RFD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Britten</u> Last <u>Britten</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>ore</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1891</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Sept 7, 1891</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-26-7343</u>	
17. INFORMANT <u>Purnell Coleman</u> Address <u>Chester Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Found dead in his room.</u> <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kirsch</u>	
ADDRESS <u>Chuck Hill Md</u>		24b. REGISTRAR'S SIGNATURE	

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE  
DEPARTMENT OF HEALTH  
ALBANY

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	

5-10-10

Death - 10-10-10

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10538

Reg. Dist. No.

10546

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>MATHEW</u>		First Middle Last <u>CHEERS</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT CHEERS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>WEBSTER CHEERS - CENTREVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/10-58</u>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>SEPT. 11</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SALEM</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL CENTREVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard C. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
Place of Birth		Usual Residence		Occupation		Cause of Death		Manner of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Physician		Signature of Nurse	
Signature of Assistant Medical Examiner		Signature of Assistant Coroner		Signature of Assistant Registrar		Signature of Assistant Physician		Signature of Assistant Nurse	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10539

10547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>H.</b> Last <b>ELLIOTT</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>28,</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1892</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Isaiah Elliott</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Jane Wright</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W.W.1</b>			
16. SOCIAL SECURITY NO. <b>213-24-2401</b>				17. INFORMANT <b>Cora J. Adams,</b> Address <b>Millington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Carcinoma</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 28, 1958</b> to <b>same date</b> , that I last saw the deceased alive on <b>Sept 28, 1958</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. H. Hamilton</b>				ADDRESS (Street, city or town, state) <b>Millington Md</b>			
PHYSICIAN'S NAME (Type) <b>H. H. HAMILTON</b>				DATE SIGNED <b>9/30/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Oct. 1, 1958</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Rural Millington, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward G. Holloway</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>			
ADDRESS <b>Millington, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>			



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of hospital		14. Name of physician		15. Name of nurse		16. Name of attendant	
17. Name of undertaker		18. Name of funeral home		19. Name of cemetery		20. Name of church	
21. Name of family		22. Name of friends		23. Name of neighbors		24. Name of community	
25. Name of school		26. Name of employer		27. Name of occupation		28. Name of residence	
29. Name of birthplace		30. Name of birth date		31. Name of birth time		32. Name of birth place	
33. Name of birth mother		34. Name of birth father		35. Name of birth mother		36. Name of birth father	
37. Name of birth mother		38. Name of birth father		39. Name of birth mother		40. Name of birth father	
41. Name of birth mother		42. Name of birth father		43. Name of birth mother		44. Name of birth father	
45. Name of birth mother		46. Name of birth father		47. Name of birth mother		48. Name of birth father	
49. Name of birth mother		50. Name of birth father		51. Name of birth mother		52. Name of birth father	
53. Name of birth mother		54. Name of birth father		55. Name of birth mother		56. Name of birth father	
57. Name of birth mother		58. Name of birth father		59. Name of birth mother		60. Name of birth father	
61. Name of birth mother		62. Name of birth father		63. Name of birth mother		64. Name of birth father	
65. Name of birth mother		66. Name of birth father		67. Name of birth mother		68. Name of birth father	
69. Name of birth mother		70. Name of birth father		71. Name of birth mother		72. Name of birth father	
73. Name of birth mother		74. Name of birth father		75. Name of birth mother		76. Name of birth father	
77. Name of birth mother		78. Name of birth father		79. Name of birth mother		80. Name of birth father	
81. Name of birth mother		82. Name of birth father		83. Name of birth mother		84. Name of birth father	
85. Name of birth mother		86. Name of birth father		87. Name of birth mother		88. Name of birth father	
89. Name of birth mother		90. Name of birth father		91. Name of birth mother		92. Name of birth father	
93. Name of birth mother		94. Name of birth father		95. Name of birth mother		96. Name of birth father	
97. Name of birth mother		98. Name of birth father		99. Name of birth mother		100. Name of birth father	

10548

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. LENGTH OF STAY IN TB <u>13 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Centerville</u>			d. STREET ADDRESS <u>Centerville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>TREVOR</u> <u>HOGG</u>			4. DATE OF DEATH Month Day Year <u>Sept</u> <u>18</u> <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10 - 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Building</u>		11. BIRTHPLACE (State or foreign country) <u>Brownsville Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Frank J. Hogg</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Alice Bosler</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>219-34-3537</u>			17. INFORMANT <u>Mary C. D. Hogg</u> Address <u>Centerville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio Sclerotic Cardio Vascular</u> DISEASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yr</u> (c) <u>10 yr</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis - 5 year Co. Rector - 6 year</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Sept 18</u> , 1958, to <u>Sept 19</u> , 1958, that I last saw the deceased alive on <u>Sept 17</u> , 1958, and that death occurred at <u>10 ST</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 S Liberty St</u> DATE SIGNED <u>Centerville Md</u>					
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D. <u>104 S Liberty St</u>					
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u> <u>Centerville Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Sept 19 - 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>	
22d. LOCATION (City, town, or county)		(State) <u>Washington Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Basting Basting Bros Centerville Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10549

CERTIFICATE OF DEATH

Reg. Dist. No.

10541

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM T. LIVINGSTON</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 5 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11 - 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CONSTANT LIVINGSTON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-4847</u>		17. INFORMANT Address <u>MRS. LEONARD HOXTER CHESTER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>atherosclerotic cerebral vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive Cardio-vascular disease</u> (c) <u>general Arteriosclerosis ess. hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> <u>several years</u> <u>years (5)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hyper trophy of prostate (malignancy) operation 8/15/58</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St.</u>		20f. (City or town) (County) (State) <u>Stevensville Md</u>	
21. I certify that I attended the deceased from <u>May 10 1956</u> to <u>Sept. 5th 1958</u> , that I last saw the deceased alive on <u>Sept 5 1958</u> , and that death occurred at <u>3:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Stevensville Md</u> <u>Sept 6, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>				<u>STEVENSVILLE Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 8</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W. Lane Church Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis E. Kline</u>	

CERTIFICATE OF DEATH

1923

NAME

SEX

AGE

DATE

TIME

PLACE

Cause

Diagnosis

Signature

Witness

Registrar

Physician

Coroner

Funeral

Interment

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10550

CERTIFICATE OF DEATH

Reg. Dist. No.

10542

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>			
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TIMMS NURSING HOME</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELSON STEVENS</u>				4. DATE OF DEATH Month Day Year <u>SEPT 13 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEMUEL STEVENS</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Urie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS ADDIE JACQUETTE ROCK HALL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>58</u> , to <u>Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>58</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Irvin D Hoyt</u> M.D. <u>Quantico, Md.</u> PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 15th</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jessie Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer Lane Church Hill Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 9, Film G234, 10/1/58  
**CERTIFICATE OF DEATH**

10543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sudlersville</b> c. LENGTH OF STAY in 1b <b>Rural Sudlersville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Sudlersville</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>TAYLOR</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April, 9, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Octavia Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-07-6668</b>	
17. INFORMANT <b>Mrs. Estella Taylor, Sudlersville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Infarct</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pain &amp; fever noted at autopsy in 1930</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>70</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>20 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1950</b> , to <b>Sept 29, 1958</b> , that I last saw the deceased alive on <b>Feb 19</b> , 1958, and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. H. Metcalfe</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Sudlersville, Md. 9/30/58</b>	
PHYSICIAN'S NAME (Type) <b>C. H. METCALFE</b>		<b>SUDLERSVILLE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 2, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pondtown, Rural Sudlersville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward G. Gellows, Millington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Orlino S. Knecht</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10552

CERTIFICATE OF DEATH

10544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alexander</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hadnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Alma Lopez</u>		Address <u>Grasonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lung</u> <u>157X</u> DUE TO <u>Ca of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Same</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>58</u> , to <u>Sept.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 12</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grasonville, Md.</u> DATE SIGNED <u>9/23/58</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u> <u>Queenstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 26</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar G. Kane</u> ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>SEP 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>

ILLINOIS STATE DEPARTMENT OF HEALTH—JULY 1966

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10545

10553

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>		c. LENGTH OF STAY IN 1b <u>18 YRS.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>PRICE</u> Middle <u>WALTERS</u> Last		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 11 - 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>SAMUEL C. WALTERS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA FOGWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. LUCY WALTERS</u>		Address <u>BARCLAY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 20</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TEMPLEVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>TEMPLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN KANSAS STATE DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Manner of Death	
9. Signature of Medical Examiner		10. Signature of Coroner		11. Signature of Registrar		12. Signature of Physician	
13. Signature of Nurse		14. Signature of Pathologist		15. Signature of Forensic Scientist		16. Signature of Toxicologist	
17. Signature of Anatomist		18. Signature of Radiologist		19. Signature of Microscopist		20. Signature of Histologist	
21. Signature of Embryologist		22. Signature of Zoologist		23. Signature of Botanist		24. Signature of Geologist	
25. Signature of Astronomer		26. Signature of Meteorologist		27. Signature of Oceanographer		28. Signature of Climatologist	
29. Signature of Environmental Scientist		30. Signature of Public Health Officer		31. Signature of Health Commissioner		32. Signature of State Health Officer	
33. Signature of State Health Officer		34. Signature of State Health Officer		35. Signature of State Health Officer		36. Signature of State Health Officer	
37. Signature of State Health Officer		38. Signature of State Health Officer		39. Signature of State Health Officer		40. Signature of State Health Officer	
41. Signature of State Health Officer		42. Signature of State Health Officer		43. Signature of State Health Officer		44. Signature of State Health Officer	
45. Signature of State Health Officer		46. Signature of State Health Officer		47. Signature of State Health Officer		48. Signature of State Health Officer	
49. Signature of State Health Officer		50. Signature of State Health Officer		51. Signature of State Health Officer		52. Signature of State Health Officer	
53. Signature of State Health Officer		54. Signature of State Health Officer		55. Signature of State Health Officer		56. Signature of State Health Officer	
57. Signature of State Health Officer		58. Signature of State Health Officer		59. Signature of State Health Officer		60. Signature of State Health Officer	
61. Signature of State Health Officer		62. Signature of State Health Officer		63. Signature of State Health Officer		64. Signature of State Health Officer	
65. Signature of State Health Officer		66. Signature of State Health Officer		67. Signature of State Health Officer		68. Signature of State Health Officer	
69. Signature of State Health Officer		70. Signature of State Health Officer		71. Signature of State Health Officer		72. Signature of State Health Officer	
73. Signature of State Health Officer		74. Signature of State Health Officer		75. Signature of State Health Officer		76. Signature of State Health Officer	
77. Signature of State Health Officer		78. Signature of State Health Officer		79. Signature of State Health Officer		80. Signature of State Health Officer	
81. Signature of State Health Officer		82. Signature of State Health Officer		83. Signature of State Health Officer		84. Signature of State Health Officer	
85. Signature of State Health Officer		86. Signature of State Health Officer		87. Signature of State Health Officer		88. Signature of State Health Officer	
89. Signature of State Health Officer		90. Signature of State Health Officer		91. Signature of State Health Officer		92. Signature of State Health Officer	
93. Signature of State Health Officer		94. Signature of State Health Officer		95. Signature of State Health Officer		96. Signature of State Health Officer	
97. Signature of State Health Officer		98. Signature of State Health Officer		99. Signature of State Health Officer		100. Signature of State Health Officer	